

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 2 8 1 1 2							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE OF DEATH	
BENJAMIN		COLLINS		11		16		79	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		BLACK		12 10 99		80		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.	
Md.		USA				Dorchester			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		ESHC		LABOR					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Somerset		Westover		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 211	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Samuel J		Elizabeth		NO				Marie Collins P.O. Box 211 Westover Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
481- Solar Pneumonia								4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
EMPHYSEMA; ARTERIOSCLEROTIC CARDIO-VASC DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (b) (this hospital) attended the deceased from 11-16-19 79, to 11-16-19 79, that (I) (we) lost the deceased alive on 11-16-19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
DONALD F. BARTLEY M.D.		M.D.				11-16-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
DONALD F. BARTLEY M.D.		EASTERN SHORE HUSB. CTR. CAMBRIDGE, MD 21613		Burial		11-20-79		St. James	
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. H. James III 250 Church St		NOV 21 1979		[Signature]		NOV 21 1979		[Signature]	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 8 1 1 3

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Viola J. Comegys			2a. DATE OF DEATH MONTH 11 DAY 23 YEAR 79			2b. HOUR 7⁵⁵ P. M	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH 9 DAY 12 YEAR 00		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MD		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Isaac MIDDLE Johnson LAST Johnson		15. MOTHER'S MAIDEN NAME FIRST Hannah MIDDLE 1 LAST Martin		16. ADDRESS Camb. Md. 833 Fairmont Ave			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		17b. SOCIAL SECURITY NO. 215-12-6470		17. INFORMANT Clifton Comegys ADDRESS 833 Fairmont Ave			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism, right 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION 11-15-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PA Descending Colon		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-13- 19 79 , to 11-23- 19 79 , that (I) (we) last saw the deceased alive on 11-23- 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not) view the body after death.							
22b. SIGNATURE J. Edwin Fasset		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-23-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Edwin Fasset				22e. ADDRESS P.O. Box 576 Cambridge MD 21613			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-1-79		23c. NAME OF CEMETERY OR CREMATORY John Wesley Cem		23d. LOCATION CITY OR TOWN Millington COUNTY Kent STATE Md.	
24. FUNERAL DIRECTOR NAME L.H. Boardley ADDRESS 603 Washington St. Camb., Md				25a. DATE REC'D. BY REGISTRAR NOV 30 1979		25b. BY Barney A. Brady	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 8 1 1 4

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		11-02-79		12.30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		10 15 91		88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Dorchester MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge, Md.		Cambridge House, Cambridge, Md.		Unknown			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Dorchester		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Joseph Sparks		Sarah Anderson		No		219-34-4112	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Verna Asplen		Cambridge, Md.		Cardio-Respiratory arrest			
				410 - Acute M. Infarction			
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
				ASCVD, Dysrhythmic B. Syndrome			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/10/79, 19, to 7/12/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		E. Tanman		MD		11-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
E. Tanman		17 Franklin St. Cambridge, Md 21613		Burial		11-5-79	
				23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
				Church Hill		Church Hill O.A. Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John P. Koulas		NOV 08 1979		Therese McCreedy			

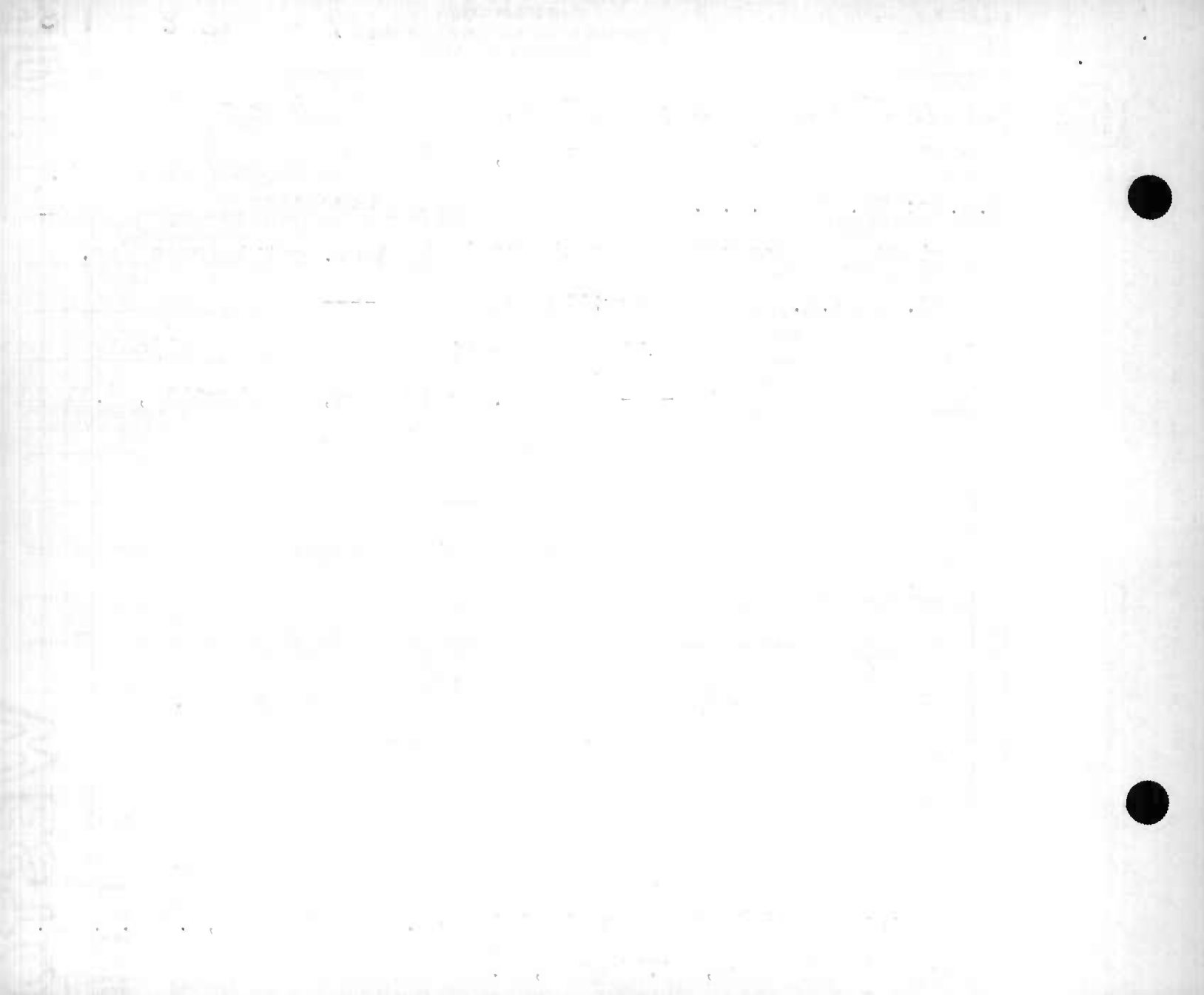
05-2-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		MIN.											
mazie Jane Hall								11-6-79								9:05		AM											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY									
Female		White		July 9, 1895		84		MONTHS		DAYS		Dorchester		Cambridge		Dorchester General Hospital		Asst. Postmistress Gov.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Q.A.Co; Md.		U.S.A.				Dorchester		Cambridge		Dorchester General Hospital		Asst. Postmistress Gov.				Md.		Q.A.		Templeville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		-----					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH		19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		21a. AUTOPSY?		21b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		22a. SIGNATURE		22b. PHYSICIAN'S NAME		22c. ADDRESS					
Alexander		Jennie		No		218-40-7379		Mrs. Bessie Ware, Templeville, Md. 21670		4280						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Whitely		UWDRAI		400 AURORA ST Cambridge Md 21613					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		21a. AUTOPSY?		21b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		22a. SIGNATURE		22b. PHYSICIAN'S NAME		22c. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		23f. STATE			
PART I. DEATH WAS CAUSED BY:																Burial		11/10/79		Templeville Cem.		Templeville		Q.A.		Md.			
IMMEDIATE CAUSE (a)																													
DUE TO, OR AS A CONSEQUENCE OF																													
(b)																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
as above																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. DATE OF INJURY		21h. TIME OF DEATH		21i. DATE OF DEATH		21j. TIME OF DEATH		21k. DATE OF DEATH		21l. TIME OF DEATH		21m. DATE OF DEATH		21n. TIME OF DEATH		21o. DATE OF DEATH	
		10 30 1979		fx of Hip		Nursing Home		Williamsbury, Md		Williamsbury		10 30 1979		11/6		11/6		11/6		11/6		11/6		11/6		11/6		11/6	
22a. I certify that (I) (this hospital) attended the deceased from		22b. I certify that (I) (this hospital) attended the deceased from		22c. I certify that (I) (this hospital) attended the deceased from		22d. I certify that (I) (this hospital) attended the deceased from		22e. I certify that (I) (this hospital) attended the deceased from		22f. I certify that (I) (this hospital) attended the deceased from		22g. I certify that (I) (this hospital) attended the deceased from		22h. I certify that (I) (this hospital) attended the deceased from		22i. I certify that (I) (this hospital) attended the deceased from		22j. I certify that (I) (this hospital) attended the deceased from		22k. I certify that (I) (this hospital) attended the deceased from		22l. I certify that (I) (this hospital) attended the deceased from		22m. I certify that (I) (this hospital) attended the deceased from		22n. I certify that (I) (this hospital) attended the deceased from		22o. I certify that (I) (this hospital) attended the deceased from	
saw the deceased alive on		11/5 1979		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.		11/6 1979		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.		11/6 1979		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.		11/6 1979		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.		11/6 1979		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.		11/6 1979		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.		11/6 1979		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.	
22a. SIGNATURE		22b. PHYSICIAN'S NAME		22c. ADDRESS		22d. DATE SIGNED		22e. DATE SIGNED		22f. DATE SIGNED		22g. DATE SIGNED		22h. DATE SIGNED		22i. DATE SIGNED		22j. DATE SIGNED		22k. DATE SIGNED		22l. DATE SIGNED		22m. DATE SIGNED		22n. DATE SIGNED		22o. DATE SIGNED	
Whitely		UWDRAI		400 AURORA ST Cambridge Md 21613		11/6/79		11/6/79		11/6/79		11/6/79		11/6/79		11/6/79		11/6/79		11/6/79		11/6/79		11/6/79		11/6/79		11/6/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		23f. STATE		23g. DATE		23h. TIME		23i. DATE		23j. TIME		23k. DATE		23l. TIME		23m. DATE		23n. TIME		23o. DATE	
Burial		11/10/79		Templeville Cem.		Templeville		Q.A.		Md.		NOV 15 1979		21651		21651		21651		21651		21651		21651		21651		21651	
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.		Edward Fellows & Son, Millington, Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 1 1 6	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Grayson Levi Hurley					2a. DATE OF DEATH MONTH DAY YEAR 11-5-79				2b. HOUR 9:42 AM		
3. SEX M		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 6 28 10		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DORCHESTER Co., MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.					
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAIL CARRIER RETIRED		12b. KIND OF BUSINESS OR INDUSTRY POSTAL SERVICE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 303 SUNBURST HWY.	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN L. HURLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE OREM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II NAVY 214-07-8018		17. INFORMANT ADDRESS WIFE - SARAH (SAME)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 HR 45 MIN</u> <u>10+ YEARS</u> <u>10+ YEARS</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>HYPERTENSION, CONTROLLED; OBESITY, MODERATE</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/23 19 68</u> to <u>11-5 19 79</u> , that (I) (we) last saw the deceased alive on <u>11-5 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <u>Donald R. McWilliams, MD.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11-5-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. McWILLIAMS, M.D.				22e. ADDRESS 308 GAY ST. CAMBRIDGE, MD - 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 11/8/79		23c. NAME OF CEMETERY OR CREMATORY Maryland Vets		23d. LOCATION CITY OR TOWN COUNTY STATE Beulah Dorchester Md.			
24. FUNERAL DIRECTOR NAME Thomas Funeral Home				P.O. Box 348 Cambridge Md. 21613				25a. DATE REC'D. BY REGISTRAR NOV 13 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

FD

31

55

16

2512340906

4

54. 1. 2014/2015

Chamberlain, J. M., Patterson, G. R., & Reid, J. B. (1983). The effectiveness of parent training programs in the treatment of conduct problems in children. *Journal of Consulting and Clinical Psychology, 51*, 34-47.

414

1A-3510

354410

933904

In fact,

WILSON, J. H. (1962-1963) 1962-1963 (24/10)

22

3. The following are the names of the persons who have been appointed to the various committees of the Board of Directors:

10/15/88 201

10/10/2010 10:10:10 AM

[illegible]

95-2-4

X

James P. Williams, Jr.

James E. Thompson, 405 East St. University, MD - 2012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 8 1 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Boland Jackson			2a. DATE OF DEATH MONTH 11 DAY 9 YEAR 79			2b. HOUR 830 P.M.	
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH MONTH 6 DAY 29 YEAR 91		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Oyster Shucker	
13a STATE Maryland		13b COUNTY Dorchester		13c CITY OR TOWN Cambridge		12b. KIND OF BUSINESS OR INDUSTRY Phillips	
14 FATHER'S NAME FIRST Thomas MIDDLE Jackson LAST Jackson		15 MOTHER'S MAIDEN NAME FIRST Francis MIDDLE Johnson LAST Johnson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b SOCIAL SECURITY NO. 214-07-8194		17 INFORMANT ADDRESS Eva Slagum Jackson, Rt. 1, Box 48, E. New Market, Md. 21631			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 2030 DUE TO, OR AS A CONSEQUENCE OF (b) ASHO c Pern. Paenemaker Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH 10 DAY 19 YEAR 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —			
22a. I certify that (I) (this hospital) attended the deceased from 10/26, 1979 to 11/9, 1979 , that (I) (we) last saw the deceased alive on 11/9, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE — DEGREE —				22c. DATE SIGNED —			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HINDRAI MEHTA				22e. ADDRESS 440 Aurora St. Cambridge Md 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 14, 1979		23c. NAME OF CEMETERY OR CREMATORY East New Market Cem.		23d. LOCATION CITY OR TOWN E. New Market, Dor., Maryland COUNTY — STATE —	
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St. ADDRESS Federalburg,				25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE —	

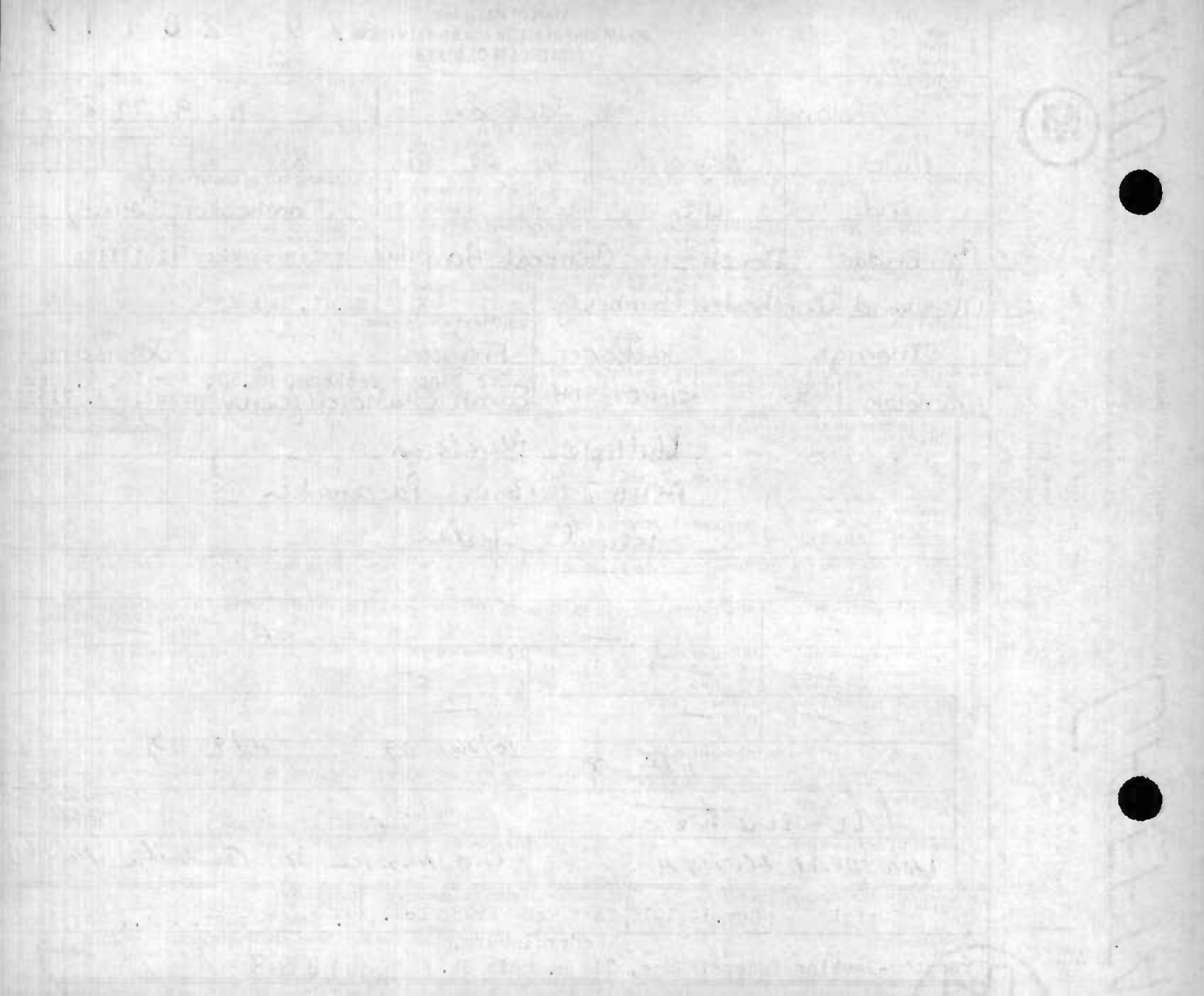
35
63
35
19
1
29
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 8 1 1 8

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST CHARLES JONES		MONTH DAY YEAR 11 5 79	
3 SEX M		2b. HOUR 6 15 AM	
4 RACE N		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR 1 30 84		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTERN SHORE Hosp CENTER	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Dorchester	
13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 611 Cross st			
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.	
17. INFORMANT Evelyn Jones		ADDRESS 611 Cross st	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 4291 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CVA & Rt. Hemiplegia</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>Jan 19 78</u> , 19 <u>78</u> , to <u>6 Feb</u> , 19 <u>79</u> , that he (we) last saw the deceased alive on <u>4 Feb 79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, I did not view the body after death.)			
22b. SIGNATURE <u>E.D. DeBarnater</u>		22c. DATE SIGNED 5 Feb 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.D. DeBarnater, MD		22e. ADDRESS E.S.H.C. Cambridge, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/9/79	
23c. NAME OF CEMETERY OR CREMATORY Thompson Town		23d. LOCATION CITY OR TOWN COUNTY STATE Thompson Dor. MD	
24. FUNERAL DIRECTOR NAME St. Clare Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 8 1979	
25b. REGISTRAR'S SIGNATURE <u>Patricia Kelly</u>			



THE
UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C.

TO THE
LANDS
MANAGED BY THE
BUREAU OF LAND MANAGEMENT
FOR THE
UNITED STATES DEPARTMENT OF THE INTERIOR

BY
THE
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 8 1 1 9

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) HARRISON LEONARD JOYNER <i>HARRISON L. Joyner</i>		2a. DATE OF DEATH MONTH DAY YEAR Nov. 4 1979		2b. HOUR M	
3 SEX M.	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 1/30/ 1902		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester		10 CITY OR TOWN OF DEATH Cambridge		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) painter		12b KIND OF BUSINESS OR INDUSTRY painting		13a STATE Md.	
13b COUNTY Dorchester		13c CITY OR TOWN Cambridge		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST W. Leonard Joyner		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Cobb		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b SOCIAL SECURITY NO. 229-01-1651		17 INFORMANT ADDRESS Mrs. Bertha Joyner, same as 13 e		18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure. 496- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Airway Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Degenerative Heart Disease with Atrial Fibrillation					
19a DATE OF OPERATION 10/30/79		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Heart Disease with Atrial Fibrillation		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 10/30/79	
21f LOCATION STREET CITY OR TOWN COUNTY STATE 11/4/79		22a I certify that (I) (this hospital) attended the deceased from 10/30/79 to 11/4/79 , that (I) (we) last saw the deceased alive on 10/30/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE DEGREE Curran	
22c DATE SIGNED		22d PHYSICIAN'S NAME (TYPE OR PRINT) Curran		22e ADDRESS Curran Funeral Home, 308 High St.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE 11/7/79		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Md.		24 FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St.		25a DATE REC'D. BY REGISTRAR (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) (148) (149) (150) (151) (152) (153) (154) (155) (156) (157) (158) (159) (160) (161) (162) (163) (164) (165) (166) (167) (168) (169) (170) (171) (172) (173) (174) (175) (176) (177) (178) (179) (180) (181) (182) (183) (184) (185) (186) (187) (188) (189) (190) (191) (192) (193) (194) (195) (196) (197) (198) (199) (200) (201) (202) (203) (204) (205) (206) (207) (208) (209) (210) (211) (212) (213) (214) (215) (216) (217) (218) (219) (220) (221) (222) (223) (224) (225) (226) (227) (228) (229) (230) (231) (232) (233) (234) (235) (236) (237) (238) (239) (240) (241) (242) (243) (244) (245) (246) (247) (248) (249) (250) (251) (252) (253) (254) (255) (256) (257) (258) (259) (260) (261) (262) (263) (264) (265) (266) (267) (268) (269) (270) (271) (272) (273) (274) (275) (276) (277) (278) (279) (280) (281) (282) (283) (284) (285) (286) (287) (288) (289) (290) (291) (292) (293) (294) (295) (296) (297) (298) (299) (300) (301) (302) (303) (304) (305) (306) (307) (308) (309) (310) (311) (312) (313) (314) (315) (316) (317) (318) (319) (320) (321) (322) (323) (324) (325) (326) (327) (328) (329) (330) (331) (332) (333) (334) (335) (336) (337) (338) (339) (340) (341) (342) (343) (344) (345) (346) (347) (348) (349) (350) (351) (352) (353) (354) (355) (356) (357) (358) (359) (360) (361) (362) (363) (364) (365) (366) (367) (368) (369) (370) (371) (372) (373) (374) (375) (376) (377) (378) (379) (380) (381) (382) (383) (384) (385) (386) (387) (388) (389) (390) (391) (392) (393) (394) (395) (396) (397) (398) (399) (400) (401) (402) (403) (404) (405) (406) (407) (408) (409) (410) (411) (412) (413) (414) (415) (416) (417) (418) (419) (420) (421) (422) (423) (424) (425) (426) (427) (428) (429) (430) (431) (432) (433) (434) (435) (436) (437) (438) (439) (440) (441) (442) (443) (444) (445) (446) (447) (448) (449) (450) (451) (452) (453) (454) (455) (456) (457) (458) (459) (460) (461) (462) (463) (464) (465) (466) (467) (468) (469) (470) (471) (472) (473) (474) (475) (476) (477) (478) (479) (480) (481) (482) (483) (484) (485) (486) (487) (488) (489) (490) (491) (492) (493) (494) (495) (496) (497) (498) (499) (500) (501) (502) (503) (504) (505) (506) (507) (508) (509) (510) (511) (512) (513) (514) (515) (516) (517) (518) (519) (520) (521) (522) (523) (524) (525) (526) (527) (528) (529) (530) (531) (532) (533) (534) (535) (536) (537) (538) (539) (540) (541) (542) (543) (544) (545) (546) (547) (548) (549) (550) (551) (552) (553) (554) (555) (556) (557) (558) (559) (560) (561) (562) (563) (564) (565) (566) (567) (568) (569) (570) (571) (572) (573) (574) (575) (576) (577) (578) (579) (580) (581) (582) (583) (584) (585) (586) (587) (588) (589) (590) (591) (592) (593) (594) (595) (596) (597) (598) (599) (600) (601) (602) (603) (604) (605) (606) (607) (608) (609) (610) (611) (612) (613) (614) (615) (616) (617) (618) (619) (620) (621) (622) (623) (624) (625) (626) (627) (628) (629) (630) (631) (632) (633) (634) (635) (636) (637) (638) (639) (640) (641) (642) (643) (644) (645) (646) (647) (648) (649) (650) (651) (652) (653) (654) (655) (656) (657) (658) (659) (660) (661) (662) (663) (664) (665) (666) (667) (668) (669) (670) (671) (672) (673) (674) (675) (676) (677) (678) (679) (680) (681) (682) (683) (684) (685) (686) (687) (688) (689) (690) (691) (692) (693) (694) (695) (696) (697) (698) (699) (700) (701) (702) (703) (704) (705) (706) (707) (708) (709) (710) (711) (712) (713) (714) (715) (716) (717) (718) (719) (720) (721) (722) (723) (724) (725) (726) (727) (728) (729) (730) (731) (732) (733) (734) (735) (736) (737) (738) (739) (740) (741) (742) (743) (744) (745) (746) (747) (748) (749) (750) (751) (752) (753) (754) (755) (756) (757) (758) (759) (760) (761) (762) (763) (764) (765) (766) (767) (768) (769) (770) (771) (772) (773) (774) (775) (776) (777) (778) (779) (780) (781) (782) (783) (784) (785) (786) (787) (788) (789) (790) (791) (792) (793) (794) (795) (796) (797) (798) (799) (800) (801) (802) (803) (804) (805) (806) (807) (808) (809) (810) (811) (812) (813) (814) (815) (816) (817) (818) (819) (820) (821) (822) (823) (824) (825) (826) (827) (828) (829) (830) (831) (832) (833) (834) (835) (836) (837) (838) (839) (840) (841) (842) (843) (844) (845) (846) (847) (848) (849) (850) (851) (852) (853) (854) (855) (856) (857) (858) (859) (860) (861) (862) (863) (864) (865) (866) (867) (868) (869) (870) (871) (872) (873) (874) (875) (876) (877) (878) (879) (880) (881) (882) (883) (884) (885) (886) (887) (888) (889) (890) (891) (892) (893) (894) (895) (896) (897) (898) (899) (900) (901) (902) (903) (904) (905) (906) (907) (908) (909) (910) (911) (912) (913) (914) (915) (916) (917) (918) (919) (920) (921) (922) (923) (924) (925) (926) (927) (928) (929) (930) (931) (932) (933) (934) (935) (936) (937) (938) (939) (940) (941) (942) (943) (944) (945) (946) (947) (948) (949) (950) (951) (952) (953) (954) (955) (956) (957) (958) (959) (960) (961) (962) (963) (964) (965) (966) (967) (968) (969) (970) (971) (972) (973) (974) (975) (976) (977) (978) (979) (980) (981) (982) (983) (984) (985) (986) (987) (988) (989) (990) (991) (992) (993) (994) (995) (996) (997) (998) (999) (1000) (1001) (1002) (1003) (1004) (1005) (1006) (1007) (1008) (1009) (1010) (1011) (1012) (1013) (1014) (1015) (1016) (1017) (1018) (1019) (1020) (1021) (1022) (1023) (1024) (1025) (1026) (1027) (1028) (1029) (1030) (1031) (1032) (1033) (1034) (1035) (1036) (1037) (1038) (1039) (1040) (1041) (1042) (1043) (1044) (1045) (1046) (1047) (1048) (1049) (1050) (1051) (1052) (1053) (1054) (1055) (1056) (1057) (1058) (1059) (1060) (1061) (1062) (1063) (1064) (1065) (1066) (1067) (1068) (1069) (1070) (1071) (1072) (1073) (1074) (1075) (1076) (1077) (1078) (1079) (1080) (1081) (1082) (1083) (1084) (1085) (1086) (1087) (1088) (1089) (1090) (1091) (1092) (1093) (1094) (1095) (1096) (1097) (1098) (1099) (1100) (1101) (1102) (1103) (1104) (1105) (1106) (1107) (1108) (1109) (1110) (1111) (1112) (1113) (1114) (1115) (1116) (1117) (1118) (1119) (1120) (1121) (1122) (1123) (1124) (1125) (1126) (1127) (1128) (1129) (1130) (1131) (1132) (1133) (1134) (1135) (1136) (1137) (1138) (1139) (1140) (1141) (1142) (1143) (1144) (1145) (1146) (1147) (1148) (1149) (1150) (1151) (1152) (1153) (1154) (1155) (1156) (1157) (1158) (1159) (1160) (1161) (1162) (1163) (1164) (1165) (1166) (1167) (1168) (1169) (1170) (1171) (1172) (1173) (1174) (1175) (1176) (1177) (1178) (1179) (1180) (1181) (1182) (1183) (1184) (1185) (1186) (1187) (1188) (1189) (1190) (1191) (1192) (1193) (1194) (1195) (1196) (1197) (1198) (1199) (1200) (1201) (1202) (1203) (1204) (1205) (1206) (1207) (1208) (1209) (1210) (1211) (1212) (1213) (1214) (1215) (1216) (1217) (1218) (1219) (1220) (1221) (1222) (1223) (1224) (1225) (1226) (1227) (1228) (1229) (1230) (1231) (1232) (1233) (1234) (1235) (1236) (1237) (1238) (1239) (1240) (1241) (1242) (1243) (1244) (1245) (1246) (1247) (1248) (1249) (1250) (1251) (1252) (1253) (1254) (1255) (1256) (1257) (1258) (1259) (1260) (1261) (1262) (1263) (1264) (1265) (1266) (1267) (1268) (1269) (1270) (1271) (1272) (1273) (1274) (1275) (1276) (1277) (1278) (1279) (1280) (1281) (1282) (1283) (1284) (1285) (1286) (1287) (1288) (1289) (1290) (1291) (1292) (1293) (1294) (1295) (1296) (1297) (1298) (1299) (1300) (1301) (1302) (1303) (1304) (1305) (1306) (1307) (1308) (1309) (1310) (1311) (1312) (1313) (1314) (1315) (1316) (1317) (1318) (1319) (1320) (1321) (1322) (1323) (1324) (1325) (1326) (1327) (1328) (1329) (1330) (1331) (1332) (1333) (1334) (1335) (1336) (1337) (1338) (1339) (1340) (1341) (1342) (1343) (1344) (1345) (1346) (1347) (1348) (1349) (1350) (1351) (1352) (1353) (1354) (1355) (1356) (1357) (1358) (1359) (1360) (1361) (1362) (1363) (1364) (1365) (1366) (1367) (1368) (1369) (1370) (1371) (1372) (1373) (1374) (1375) (1376) (1377) (1378) (1379) (1380) (1381) (1382) (1383) (1384) (1385) (1386) (1387) (1388) (1389) (1390) (1391) (1392) (1393) (1394) (1395) (1396) (1397) (1398) (1399) (1400) (1401) (1402) (1403) (1404) (1405) (1406) (1407) (1408) (1409) (1410) (1411) (1412) (1413) (1414) (1415) (1416) (1417) (1418) (1419) (1420) (1421) (1422) (1423) (1424) (1425) (1426) (1427) (1428) (1429) (1430) (1431) (1432) (1433) (1434) (1435) (1436) (1437) (1438) (1439) (1440) (1441) (1442) (1443) (1444) (1445) (1446) (1447) (1448) (1449) (1450) (1451) (1452) (1453) (1454) (1455) (1456) (1457) (1458) (1459) (1460) (1461) (1462) (1463) (1464) (1465) (1466) (1467) (1468) (1469) (1470) (1471) (1472) (1473) (1474) (1475) (1476) (1477) (1478) (1479) (1480) (1481) (1482) (1483) (1484) (1485) (1486) (1487) (1488) (1489) (1490) (1491) (1492) (1493) (1494) (1495) (1496) (1497) (1498) (1499) (1500) (1501) (1502) (1503) (1504) (1505) (1506) (1507) (1508) (1509) (1510) (1511) (1512) (1513) (1514) (1515) (1516) (1517) (1518) (1519) (1520) (1521) (1522) (1523) (1524) (1525) (1526) (1527) (1528) (1529) (1530) (1531) (1532) (1533) (1534) (1535) (1536) (1537) (1538) (1539) (1540) (1541) (1542) (1543) (1544) (1545) (1546) (1547) (1548) (1549) (1550) (1551) (1552) (1553) (1554) (1555) (1556) (1557) (1558) (1559) (1560) (1561) (1562) (1563) (1564) (1565) (1566) (1567) (1568) (1569) (1570) (1571) (1572) (1573) (1574) (1575) (1576) (1577) (1578) (1579) (1580) (1581) (1582) (1583) (1584) (1585) (1586) (1587) (1588) (1589) (1590) (1591) (1592) (1593) (1594) (1595) (1596) (1597) (1598) (1599) (1600) (1601) (1602) (1603) (1604) (1605) (1606) (1607) (1608) (1609) (1610) (1611) (1612) (1613) (1614) (1615) (1616) (1617) (1618) (1619) (1620) (1621) (1622) (1623) (1624) (1625) (1626) (1627) (1628) (1629) (1630) (1631) (1632) (1633) (1634) (1635) (1636) (1637) (1638) (1639) (1640) (1641) (1642) (1643) (1644) (1645) (1646) (1647) (1648) (1649) (1650) (1651) (1652) (1653) (1654) (1655) (1656) (1657) (1658) (1659) (1660) (1661) (1662) (1663) (1664) (1665) (1666) (1667) (1668) (1669) (1670) (1671) (1672) (1673) (1674) (1675) (1676) (1677) (1678) (1679) (1680) (1681) (1682) (1683) (1684) (1685) (1686) (1687) (1688) (1689) (1690) (1691) (1692) (1693) (1694) (1695) (1696) (1697) (1698) (1699) (1700) (1701) (1702) (1703) (1704) (1705) (1706) (1707) (1708) (1709) (1710) (1711) (1712) (1713) (1714) (1715) (1716) (1717) (1718) (1719) (1720) (1721) (1722) (1723) (1724) (1725) (1726) (1727) (1728) (1729) (1730) (1731) (1732) (1733) (1734) (1735) (1736) (1737) (1738) (1739) (1740) (1741) (1742) (1743) (1744) (1745) (1746) (1747) (1748) (1749) (1750) (1751) (1752) (1753) (1754) (1755) (1756) (1757) (1758) (1759) (1760) (1761) (1762) (1763) (1764) (1765) (1766) (1767) (1768) (1769) (1770) (1771) (1772) (1773) (1774) (1775) (1776) (1777) (1778) (1779) (1780) (1781) (1782) (1783) (1784) (1785) (1786) (1787) (1788) (1789) (1790) (1791) (1792) (1793) (1794) (1795) (1796) (1797) (1798) (1799) (1800) (1801) (1802) (1803) (1804) (1805) (1806) (1807) (1808) (1809) (1810) (1811) (1812) (1813) (1814) (1815) (1816) (1817) (1818) (1819) (1820) (1821) (1822) (1823) (1824) (1825) (1826) (1827) (1828) (1829) (1830) (1831) (1832) (1833) (1834) (1835) (1836) (1837) (1838) (1839) (1	



Nov. 4 1979

Nov 1979

Virginia U.S.A.

Cambridge Massachusetts General Hosp.

100 Mt. Pleasant Cambridge Mass

W. Leonard Towne Ellis Cobb

2472 Mt. Pleasant Towne, Mass 01901

Episcopal Church

One Church Street Boston

Cambridge, Mass

11/13/79

11/17/79
Cambridge, Mass
Cotton Funeral Home, 308 Main St.
Cotton Funeral Home, 308 Main St.
Cambridge, Mass
Cotton Funeral Home, 308 Main St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Frederick B. Marine					2a. DATE OF DEATH MONTH DAY YEAR 11-18-79			2b. HOUR 3:15 PM	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 12 97		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) minister		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13e. STREET ADDRESS Hurlock Md. RT. 2 Box 173 21603			
14. FATHER'S NAME FIRST MIDDLE LAST William J. Marine					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha E. Wheatley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-36-2681		17. INFORMANT Box 674 Hurlock Md. 21603 Preston Thomas					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 C. H. Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) ASCD: Cardiac arrhythmia									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary Infection									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. Tanman				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-18-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman				22e. ADDRESS 17 Franklin St. Cambridge Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 23, 1979		23c. NAME OF CEMETERY OR CREMATORY Eldorado Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock, Dorchester MD.			
24. FUNERAL DIRECTOR NAME G. Truman Schwab				ADDRESS 5151 Balto. National Pike. Balto. Md. 21229		25a. DATE RECEIVED BY REGISTRAR NOV 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.





FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 8 1 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GWENDOLYN D. MASSEY			2a. DATE OF DEATH MONTH 11 DAY 01 YEAR 79		2b. HOUR 1:30
3. SEX FEMALE	4. RACE Cauc.	5. DATE OF BIRTH MONTH 08 - DAY 25 - YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CAMBRIDGE House		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY HAL. Def.		13c. CITY OR TOWN EASTON
14. FATHER'S NAME Frederick W. Denys			15. MOTHER'S MAIDEN NAME EATON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-586128		17. INFORMANT PATRICIA DENYS-PATTEN
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest 911- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Food aspiration (c) Generalized atherosclerosis, Dynamic B. Syndrome			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. Tanman		DEGREE MD		22c. DATE SIGNED 11-1-1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman		22e. ADDRESS 17 Franklin St, Cambridge, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-3-1979		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory	
23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware		23e. DATE REG'D BY REGISTRAR NOV 06 1979			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.			

69
70
35
200
2
9
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

11 01 11

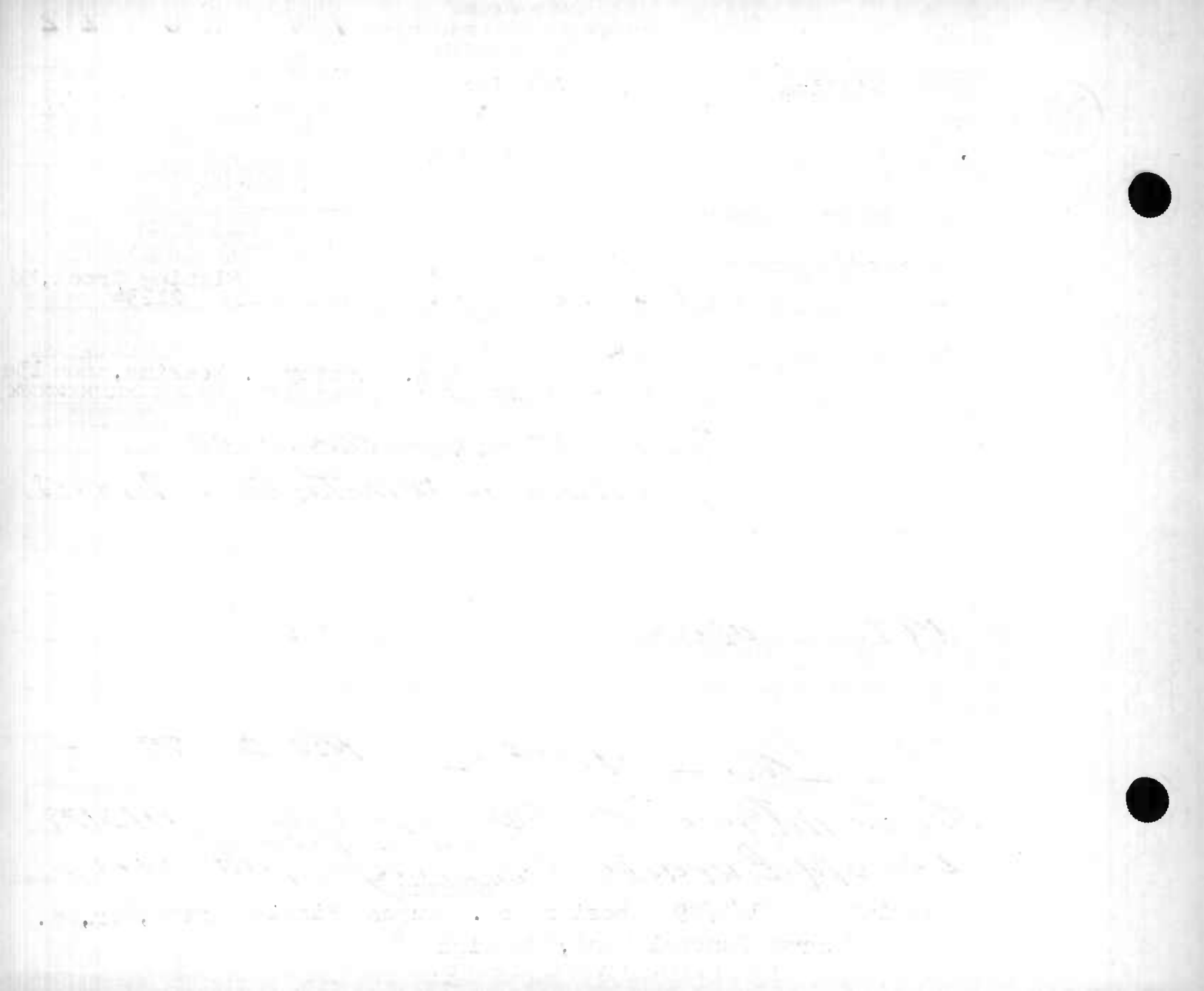
Masses



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 7 9 2 8 1 2 2 | | | |
|---|--|--|--|--|--|--|--|
| FOR
1- STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
William NMI Meekins | | | | 2a. DATE OF DEATH MONTH DAY YEAR
NOVEMBER 3, 1979 | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR
2-10-05 | | 6 AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
AMERICA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
DORCHESTER
BALLOT COUNTY 4, MD. | |
| 10 CITY OR TOWN OF DEATH
CAMBRIDGE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DORCHESTER GENERAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Waterman | | 12b. KIND OF BUSINESS OR INDUSTRY
waterman | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY DORCHESTER 13c. CITY OR TOWN FISHING CK. | | | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Fishing Creek, Md. Box 115. 21634 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Emory Meekins | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Susie Foxwell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO
014-36-5226 | | 17 INFORMANT Mrs. Dorothy E. Meekins, same 13e ADDRESS | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Recurrent adenocarcinoma</u>
1541
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>of rectum with metastases</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>2 years</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
1975 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
above | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> , 19 <u>Nov 3</u> , 19 <u>79</u> , that (I) <u>met</u> last saw the deceased alive on <u>Nov 3</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) <u>not</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Lewis M. Burdette</u> MD | | | | DEGREE
MD | | 22c. DATE SIGNED
11/3/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lewis M. Burdette | | | | 22e. ADDRESS
4 Airport St. Cambridge Md. 21613 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial | | 23b. DATE
11/6/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Hosier Mem. Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Fishing Creek, Dor. Md. | |
| 24 FUNERAL DIRECTOR NAME
Curran Funeral Home, 308 High | | | | 25a. DATE SENT BY REGISTRAR
NOV 09 1979 | | 25b. REGISTRAR'S SIGNATURE | |



Items 18b & 18c G539 1/18/80 dad STATE OF MARYLAND
 1- FOR REGISTRAR DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 2 8 1 2 3
 CERTIFICATE OF DEATH

REG. NO.

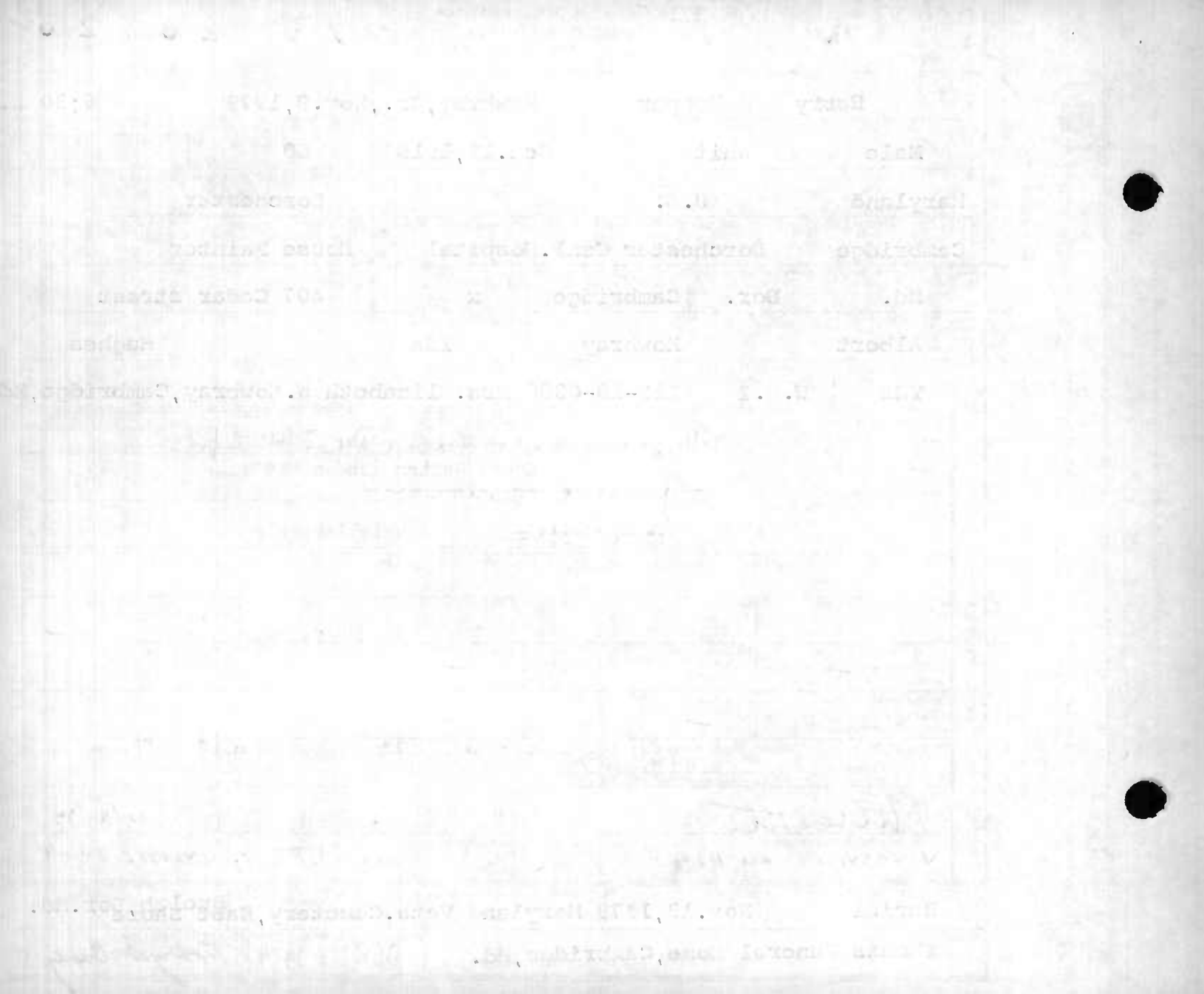
| | | | | | |
|--|------------------------|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT)
Harry Hooper Mowbray, Sr. | | 2a DATE OF DEATH MONTH DAY YEAR
Nov. 9, 1979 | | 2b HOUR
6:30 A. | |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 12, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S. | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Dorchester MD. | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Dorchester Genl. Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
House Painter | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE
Md. | | 13b CITY OR TOWN
Dor. | | 13c STREET ADDRESS
407 Cedar street | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Albert Mowbray | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ida Hughes | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b SOCIAL SECURITY NO
W.W.2 212-18-6386 | | 17 INFORMANT ADDRESS
Mrs. Elizabeth W. Mowbray, Cambridge, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Dis. & Renal failure
4049
DUE TO, OR AS A CONSEQUENCE OF Acute Gastro duodenitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastritis & Duodenitis
DUE TO, OR AS A CONSEQUENCE OF Cholelithiasis
(c) Cholelithiasis | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION
11/9/79 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
Cholelithiasis | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
Cholelithiasis | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Home | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE
Cambridge Dor. Md. | |
| 22a I certify that (I) (this hospital) attended the deceased from 6/26/79 to 11/9/79 , that (I) (we) last saw the deceased alive on 11/9/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Vinodrai Mehta | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
12/10/79 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
VINODRAI MEHTA | | 22e ADDRESS
400 AURORA ST CAMBRIDGE MD 21615 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
Nov. 13, 1979 | | 23c NAME OF CEMETERY OR CREMATORY
Maryland Vets. Cemetery, East Shore | |
| 24 FUNERAL DIRECTOR
Thomas Funeral Home, Cambridge, Md. | | 25a DATE REC'D. BY REGISTRAR
DEC 14 1979 | | 25b REGISTRAR'S SIGNATURE
Henry McCreedy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 1 9 2 8 1 2 4 | |
|---|---|---|--|--|---|
| FOR
1- STATE
REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>CLETA A PARKER</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>11-12-79</i> | | 2b. HOUR
<i>8</i> M |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Oct. 15, 1893</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>86</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Dorchester</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Cambridge</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Dorchester Genl. Hospital</i> | | 12a. USUAL OCCUPATION
(IF NOT WORKING, GIVE WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Dor.</i> | 13c. CITY OR TOWN
<i>Cambridge</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>William James Keene</i> | | | 15. MOTHER'S MAIDEN NAME
MIDDLE
<i>Idea Ruark</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>214-07-8879</i> | | 17. INFORMANT
ADDRESS
<i>James E. Parker, Cambridge, Md.,</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest.</i>
<i>888-</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 hour</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<i>Fracture left hip</i> | | | | | |
| 19a. DATE OF OPERATION
<i>9-26-79</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>fx left hip</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>5-31-79</i> 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>at feet</i> | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<i>Nursing home</i> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>Leonard Lane Cambridge Md.</i> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-12-79</i> , 19 <i>79</i> , to <i>present</i> , 19 <i>79</i> , that (we) lost saw the deceased alive on <i>10-15</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Maya</i> | | | | 22c. DATE SIGNED
<i>11-12-79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Jay Harper</i> | | | | 22e. ADDRESS
<i>1201 Hammonds Blvd.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Nov. 20, 1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Dorchester Mem. Park, Cambridge, Dor., Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Thomas Funeral Home, Cambridge, Md.,</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>NOV 23 1979</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Richard McBratney</i> | |



Oct. 12, 1993

Forchester

Forchester, Genl. H. H. H.

Cambridge

115 Beachmont Ave.

Cambridge

For.

Mr.

Mass.

Ida

Kenn

John

William

115-117-119-121-123-125-127-129-131-133-135-137-139-141-143-145-147-149-151-153-155-157-159-161-163-165-167-169-171-173-175-177-179-181-183-185-187-189-191-193-195-197-199-201-203-205-207-209-211-213-215-217-219-221-223-225-227-229-231-233-235-237-239-241-243-245-247-249-251-253-255-257-259-261-263-265-267-269-271-273-275-277-279-281-283-285-287-289-291-293-295-297-299-301-303-305-307-309-311-313-315-317-319-321-323-325-327-329-331-333-335-337-339-341-343-345-347-349-351-353-355-357-359-361-363-365-367-369-371-373-375-377-379-381-383-385-387-389-391-393-395-397-399-401-403-405-407-409-411-413-415-417-419-421-423-425-427-429-431-433-435-437-439-441-443-445-447-449-451-453-455-457-459-461-463-465-467-469-471-473-475-477-479-481-483-485-487-489-491-493-495-497-499-501-503-505-507-509-511-513-515-517-519-521-523-525-527-529-531-533-535-537-539-541-543-545-547-549-551-553-555-557-559-561-563-565-567-569-571-573-575-577-579-581-583-585-587-589-591-593-595-597-599-601-603-605-607-609-611-613-615-617-619-621-623-625-627-629-631-633-635-637-639-641-643-645-647-649-651-653-655-657-659-661-663-665-667-669-671-673-675-677-679-681-683-685-687-689-691-693-695-697-699-701-703-705-707-709-711-713-715-717-719-721-723-725-727-729-731-733-735-737-739-741-743-745-747-749-751-753-755-757-759-761-763-765-767-769-771-773-775-777-779-781-783-785-787-789-791-793-795-797-799-801-803-805-807-809-811-813-815-817-819-821-823-825-827-829-831-833-835-837-839-841-843-845-847-849-851-853-855-857-859-861-863-865-867-869-871-873-875-877-879-881-883-885-887-889-891-893-895-897-899-901-903-905-907-909-911-913-915-917-919-921-923-925-927-929-931-933-935-937-939-941-943-945-947-949-951-953-955-957-959-961-963-965-967-969-971-973-975-977-979-981-983-985-987-989-991-993-995-997-999-1001-1003-1005-1007-1009-1011-1013-1015-1017-1019-1021-1023-1025-1027-1029-1031-1033-1035-1037-1039-1041-1043-1045-1047-1049-1051-1053-1055-1057-1059-1061-1063-1065-1067-1069-1071-1073-1075-1077-1079-1081-1083-1085-1087-1089-1091-1093-1095-1097-1099-1101-1103-1105-1107-1109-1111-1113-1115-1117-1119-1121-1123-1125-1127-1129-1131-1133-1135-1137-1139-1141-1143-1145-1147-1149-1151-1153-1155-1157-1159-1161-1163-1165-1167-1169-1171-1173-1175-1177-1179-1181-1183-1185-1187-1189-1191-1193-1195-1197-1199-1201-1203-1205-1207-1209-1211-1213-1215-1217-1219-1221-1223-1225-1227-1229-1231-1233-1235-1237-1239-1241-1243-1245-1247-1249-1251-1253-1255-1257-1259-1261-1263-1265-1267-1269-1271-1273-1275-1277-1279-1281-1283-1285-1287-1289-1291-1293-1295-1297-1299-1301-1303-1305-1307-1309-1311-1313-1315-1317-1319-1321-1323-1325-1327-1329-1331-1333-1335-1337-1339-1341-1343-1345-1347-1349-1351-1353-1355-1357-1359-1361-1363-1365-1367-1369-1371-1373-1375-1377-1379-1381-1383-1385-1387-1389-1391-1393-1395-1397-1399-1401-1403-1405-1407-1409-1411-1413-1415-1417-1419-1421-1423-1425-1427-1429-1431-1433-1435-1437-1439-1441-1443-1445-1447-1449-1451-1453-1455-1457-1459-1461-1463-1465-1467-1469-1471-1473-1475-1477-1479-1481-1483-1485-1487-1489-1491-1493-1495-1497-1499-1501-1503-1505-1507-1509-1511-1513-1515-1517-1519-1521-1523-1525-1527-1529-1531-1533-1535-1537-1539-1541-1543-1545-1547-1549-1551-1553-1555-1557-1559-1561-1563-1565-1567-1569-1571-1573-1575-1577-1579-1581-1583-1585-1587-1589-1591-1593-1595-1597-1599-1601-1603-1605-1607-1609-1611-1613-1615-1617-1619-1621-1623-1625-1627-1629-1631-1633-1635-1637-1639-1641-1643-1645-1647-1649-1651-1653-1655-1657-1659-1661-1663-1665-1667-1669-1671-1673-1675-1677-1679-1681-1683-1685-1687-1689-1691-1693-1695-1697-1699-1701-1703-1705-1707-1709-1711-1713-1715-1717-1719-1721-1723-1725-1727-1729-1731-1733-1735-1737-1739-1741-1743-1745-1747-1749-1751-1753-1755-1757-1759-1761-1763-1765-1767-1769-1771-1773-1775-1777-1779-1781-1783-1785-1787-1789-1791-1793-1795-1797-1799-1801-1803-1805-1807-1809-1811-1813-1815-1817-1819-1821-1823-1825-1827-1829-1831-1833-1835-1837-1839-1841-1843-1845-1847-1849-1851-1853-1855-1857-1859-1861-1863-1865-1867-1869-1871-1873-1875-1877-1879-1881-1883-1885-1887-1889-1891-1893-1895-1897-1899-1901-1903-1905-1907-1909-1911-1913-1915-1917-1919-1921-1923-1925-1927-1929-1931-1933-1935-1937-1939-1941-1943-1945-1947-1949-1951-1953-1955-1957-1959-1961-1963-1965-1967-1969-1971-1973-1975-1977-1979-1981-1983-1985-1987-1989-1991-1993-1995-1997-1999-2001-2003-2005-2007-2009-2011-2013-2015-2017-2019-2021-2023-2025-2027-2029-2031-2033-2035-2037-2039-2041-2043-2045-2047-2049-2051-2053-2055-2057-2059-2061-2063-2065-2067-2069-2071-2073-2075-2077-2079-2081-2083-2085-2087-2089-2091-2093-2095-2097-2099-2101-2103-2105-2107-2109-2111-2113-2115-2117-2119-2121-2123-2125-2127-2129-2131-2133-2135-2137-2139-2141-2143-2145-2147-2149-2151-2153-2155-2157-2159-2161-2163-2165-2167-2169-2171-2173-2175-2177-2179-2181-2183-2185-2187-2189-2191-2193-2195-2197-2199-2201-2203-2205-2207-2209-2211-2213-2215-2217-2219-2221-2223-2225-2227-2229-2231-2233-2235-2237-2239-2241-2243-2245-2247-2249-2251-2253-2255-2257-2259-2261-2263-2265-2267-2269-2271-2273-2275-2277-2279-2281-2283-2285-2287-2289-2291-2293-2295-2297-2299-2301-2303-2305-2307-2309-2311-2313-2315-2317-2319-2321-2323-2325-2327-2329-2331-2333-2335-2337-2339-2341-2343-2345-2347-2349-2351-2353-2355-2357-2359-2361-2363-2365-2367-2369-2371-2373-2375-2377-2379-2381-2383-2385-2387-2389-2391-2393-2395-2397-2399-2401-2403-2405-2407-2409-2411-2413-2415-2417-2419-2421-2423-2425-2427-2429-2431-2433-2435-2437-2439-2441-2443-2445-2447-2449-2451-2453-2455-2457-2459-2461-2463-2465-2467-2469-2471-2473-2475-2477-2479-2481-2483-2485-2487-2489-2491-2493-2495-2497-2499-2501-2503-2505-2507-2509-2511-2513-2515-2517-2519-2521-2523-2525-2527-2529-2531-2533-2535-2537-2539-2541-2543-2545-2547-2549-2551-2553-2555-2557-2559-2561-2563-2565-2567-2569-2571-2573-2575-2577-2579-2581-2583-2585-2587-2589-2591-2593-2595-2597-2599-2601-2603-2605-2607-2609-2611-2613-2615-2617-2619-2621-2623-2625-2627-2629-2631-2633-2635-2637-2639-2641-2643-2645-2647-2649-2651-2653-2655-2657-2659-2661-2663-2665-2667-2669-2671-2673-2675-2677-2679-2681-2683-2685-2687-2689-2691-2693-2695-2697-2699-2701-2703-2705-2707-2709-2711-2713-2715-2717-2719-2721-2723-2725-2727-2729-2731-2733-2735-2737-2739-2741-2743-2745-2747-2749-2751-2753-2755-2757-2759-2761-2763-2765-2767-2769-2771-2773-2775-2777-2779-2781-2783-2785-2787-2789-2791-2793-2795-2797-2799-2801-2803-2805-2807-2809-2811-2813-2815-2817-2819-2821-2823-2825-2827-2829-2831-2833-2835-2837-2839-2841-2843-2845-2847-2849-2851-2853-2855-2857-2859-2861-2863-2865-2867-2869-2871-2873-2875-2877-2879-2881-2883-2885-2887-2889-2891-2893-2895-2897-2899-2901-2903-2905-2907-2909-2911-2913-2915-2917-2919-2921-2923-2925-2927-2929-2931-2933-2935-2937-2939-2941-2943-2945-2947-2949-2951-2953-2955-2957-2959-2961-2963-2965-2967-2969-2971-2973-2975-2977-2979-2981-2983-2985-2987-2989-2991-2993-2995-2997-2999-3001-3003-3005-3007-3009-3011-3013-3015-3017-3019-3021-3023-3025-3027-3029-3031-3033-3035-3037-3039-3041-3043-3045-3047-3049-3051-3053-3055-3057-3059-3061-3063-3065-3067-3069-3071-3073-3075-3077-3079-3081-3083-3085-3087-3089-3091-3093-3095-3097-3099-3101-3103-3105-3107-3109-3111-3113-3115-3117-3119-3121-3123-3125-3127-3129-3131-3133-3135-3137-3139-3141-3143-3145-3147-3149-3151-3153-3155-3157-3159-3161-3163-3165-3167-3169-3171-3173-3175-3177-3179-3181-3183-3185-3187-3189-3191-3193-3195-3197-3199-3201-3203-3205-3207-3209-3211-3213-3215-3217-3219-3221-3223-3225-3227-3229-3231-3233-3235-3237-3239-3241-3243-3245-3247-3249-3251-3253-3255-3257-3259-3261-3263-3265-3267-3269-3271-3273-3275-3277-3279-3281-3283-3285-3287-3289-3291-3293-3295-3297-3299-3301-3303-3305-3307-3309-3311-3313-3315-3317-3319-3321-3323-3325-3327-3329-3331-3333-3335-3337-3339-3341-3343-3345-3347-3349-3351-3353-3355-3357-3359-3361-3363-3365-3367-3369-3371-3373-3375-3377-3379-3381-3383-3385-3387-3389-3391-3393-3395-3397-3399-3401-3403-3405-3407-3409-3411-3413-3415-3417-3419-3421-3423-3425-3427-3429-3431-3433-3435-3437-3439-3441-3443-3445-3447-3449-3451-3453-3455-3457-3459-3461-3463-3465-3467-3469-3471-3473-3475-3477-3479-3481-3483-3485-3487-3489-3491-3493-3495-3497-3499-3501-3503-3505-3507-3509-3511-3513-3515-3517-3519-3521-3523-3525-3527-3529-3531-3533-3535-3537-3539-3541-3543-3545-3547-3549-3551-3553-3555-3557-3559-3561-3563-3565-3567-3569-3571-3573-3575-3577-3579-3581-3583-3585-3587-3589-3591-3593-3595-3597-3599-3601-3603-3605-3607-3609-3611-3613-3615-3617-3619-3621-3623-3625-3627-3629-3631-3633-3635-3637-3639-3641-3643-3645-3647-3649-3651-3653-3655-3657-3659-3661-3663-3665-3667-3669-3671-3673-3675-3677-3679-3681-3683-3685-3687-3689-3691-3693-3695-3697-3699-3701-3703-3705-3707-3709-3711-3713-3715-3717-3719-3721-3723-3725-3727-3729-3731-3733-3735-3737-3739-3741-3743-3745-3747-3749-3751-3753-3755-3757-3759-3761-3763-3765-3767-3769-3771-3773-3775-3777-3779-3781-3783-3785-3787-3789-3791-3793-3795-3797-3799-3801-3803-3805-3807-3809-3811-3813-3815-3817-3819-3821-3823-3825-3827-3829-3831-3833-3835-3837-3839-3841-3843-3845-3847-3849-3851-3853-3855-3857-3859-3861-3863-3865-3867-3869-3871-3873-3875-3877-3879-3881-3883-3885-3887-3889-3891-3893-3895-3897-3899-3901-3903-3905-3907-3909-3911-3913-3915-3917-3919-3921-3923-3925-3927-3929-3931-3933-3935-3937-3939-3941-3943-3945-3947-3949-3951-3953-3955-3957-3959-3961-3963-3965-3967-3969-3971-3973-3975-3977-3979-3981-3983-3985-3987-3989-3991-3993-3995-3997-3999-4001-4003-4005-4007-4009-4011-4013-4015-4017-4019-4021-4023-4025-4027-4029-4031-4033-4035-4037-4039-4041-4043-4045-4047-4049-4051-4053-4055-4057-4059-4061-4063-4065-4067-4069-4071-4073-4075-4077-4079-4081-4083-4085-4087-4089-4091-4093-4095-4097-4099-4101-4103-4105-4107-4109-4111-4113-4115-4117-4119-4121-4123-4125-4127-4129-4131-4133-4135-4137-4139-4141-4143-4145-4147-4149-4151-4153-4155-4157-4159-4161-4163-4165-4167-4169-4171-4173-4175-4177-4179-4181-4183-4185-4187-4189-4191-4193-4195-4197-4199-4201-4203-4205-4207-4209-4211-4213-4215-4217-4219-4221-4223-4225-4227-4229-4231-4233-4235-4237-4239-4241-4243-4245-4247-4249-4251-4253-4255-4257-4259-4261-4263-4265-4267-4269-4271-4273-4275-4277-4279-4281-4283-4285-4287-4289-4291-4293-4295-4297-4299-4301-4303-4305-4307-4309-4311-4313-4315-4317-4319-4321-4323-4325-4327-4329-4331-4333-4335-4337-4339-4341-4343-4345-4347-4349-4351-4353-4355-4357-4359-4361-4363-4365-4367-4369-4371-4373-4375-4377-4379-4381-4383-4385-4387-4389-4391-4393-4395-4397-4399-4401-4403-4405-4407-4409-4411-4413-4415-4417-4419-4421-4423-4425-4427-4429-4431-4433-4435-4437-4439-4441-4443-4445-4447-4449-4451-4453-4455-4457-4459-4461-4463-4465-4467-4469-4471-4473-4475-4477-4479-4481-4483-4485-4487-4489-4491-4493-4495-4497-4499-4501-4503-4505-4507-4509-4511-4513-4515-4517-4519-4521-4523-4525-4527-4529-4531-4533-4535-4537-4539-4541-4543-4545-4547-4549-4551-4553-4555-4557-4559-4561-4563-4565-4567-4569-4571-4573-4575-4577-4579-4581-4583-4585-4587-4589-4591-4593-4595-4597-4599-4601-4603-4605-4607-4609-4611-4613-4615-4617-4619-4621-4623-4625-4627-4629-4631-4633-4635-4637-4639-4641-4643-4645-4647-4649-4651-4653-4655-4657-4659-4661-4663-4665-4667-4669-4671-4673-4675-4677-4679-4681-4683-4685-4687-4689-4691-4693-4695-4697-4699-4701-4703-4705-4707-4709-4711-4713-4715-4717-4719-4721-4723-4725-4727-4729-4731-4733-4735-4737-4739-4741-4743-4745-4747-4749-4751-4753-4755-4757-4759-4761-4763-4765-4767-4769-4771-4773-4775-4777-4779-4781-4783-4785-4787-4789-4791-4793-4795-4797-4799-4801-4803-4805-4807-4809-4811-4813-4815-4817-4819-4821-4823-4825-4827-4829-4831-4833-4835-4837-4839-4841-4843-4845-4847-4849-4851-4853-4855-4857-4859-4861-4863-4865-4867-4869-4871-4873-4875-4877-4879-4881-4883-4885-4887-4889-4891-4893-4895-4897-4899-4901-4903-4905-4907-4909-4911-4913-4915-4917-4919-4921-4923-4925-4927-4929-4931-4933-4935-4937-4939-4941-4943-4945-4947-4949-4951-4953-4955-4957-4959-4961-4963-4965-4967-4969-4971-4973-4975-4977-4979-4981-4983-4985-4987-4989-4991-4993-4995-4997-4999-5001-5003-5005-5007-5009-5011-5013-5015-5017-5019-5021-5023-5025-5027-5029-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 8 1 2 5

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
COREAN - PARKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11 15 1979 | | | 2b. HOUR
9 20 PM | | | | |
| 3. SEX
F | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 3 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
DORCHESTER MD. | | | | |
| 10. CITY OR TOWN OF DEATH
CAMBRIDGE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DORCHESTER GENERAL HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
DORCH. | | 13c. CITY OR TOWN
CAMP. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
610 MUIR STREET | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES ANDERSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY RACHEL JOHNSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
- | | | 16b. SOCIAL SECURITY NO.
213-20-7125 | | 17. INFORMANT
ADDRESS
MARZELLA JONES CAMBRIDGE, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>
1519
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>HEMORRHAGE FROM ADENOCARCINOMA</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) <u>DUE TO, OR AS A CONSEQUENCE OF OF THE STOMACH</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>~ 5 min</u>
<u>45 days</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>CHEST MASS, SYPHOMASTECTOMY FOR CA.</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
9/28/79 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
UPPER GI BLEEDING | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the medical) attended the deceased from <u>9/27</u> 19 <u>79</u> to <u>11/15</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Hubert L. Fiery MD</u> | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
11/15/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUBERT L. FIERY MD | | | 22e. ADDRESS
6 AURORA ST CAMB MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
11/20/79 | | 23c. NAME OF CEMETERY OR CREMATORY
BETHEL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CAMBRIDGE DOR. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
Indurich C. ... | | | ADDRESS
CAMBRIDGE, MD. | | | 25a. DATE REC'D. BY REGISTRAR
NOV 26 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 8 1 2 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|-----------------------------|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
NORMA NORTH PHILLIPS | | | 2a DATE OF DEATH
MONTH DAY YEAR
Nov. 23, 1979 | | | 2b HOUR
9 A.M. | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
July 8 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
DORCHESTER MD. | | | |
| 10 CITY OR TOWN OF DEATH
Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Dorchester General Hosp. | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Worker | | 12b KIND OF BUSINESS OR INDUSTRY
Shellfish | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
Maryland Dorchester Fishing Creek | | | 13b INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c STREET ADDRESS
Rural | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John North | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Betty Tyler | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-16-7160 | | 17 INFORMANT ADDRESS
Mrs. Betty Parks, Fishing Creek, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u>
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from Jan 11/21 19 79, to death 19 79, that (1) (we) lost saw the deceased alive on above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
ARWILLER | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
11/26/79 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS
400 Maryland Ave. 21613 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b DATE
11-25-79 | | 23c NAME OF CEMETERY OR CREMATORY
Dorchester Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Cambridge, Dorch., Md. | | | |
| 24 FUNERAL DIRECTOR
NAME
Curran Funeral Home | | ADDRESS
308 High St.
Cambridge, Md. | | 25a DATE REC'D. BY REGISTRAR
NOV 27 1979 | | 25b REGISTRAR'S SIGNATURE
Betty Parks | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| 3 SEX | | | | | 4 RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
ADDRESS | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | 22b. SIGNATURE
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. DATE SIGNED | | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME | | | | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | |

BP _____



Greenboro

11-8-70

Initial

Greenboro

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 28128 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Frederick Trumble | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 11 26, 79 | |
| 3. SEX m 4. RACE Wh 5. DATE OF BIRTH (MONTH DAY YEAR) JAN 12, 1927 6. AGE (IN YEARS) (LAST BIRTHDAY) 52 7. IF UNDER 24 YRS. MONTHS DAYS HOURS MIN | | | | | | | | | | 2b. HOUR 7pM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 11 26, 1979 2d. HOUR 7pM | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen. Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BANKER 12b. KIND OF BUSINESS OR INDUSTRY BANK | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MONT. 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS JOLIET ST 3925 | | | | | | | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) PRESTON F. TRUMBLE 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) ELLA V. CARPENTER | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II 16b. SOCIAL SECURITY NO. 224-32-9765 17. INFORMANT LUCILLE B. TRUMBLE ADDRESS SAME AS 13 WIFE WIFE | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr min | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____ | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK _____ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ 21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____ | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John Mace Jr TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER DATE SIGNED 11/24/79 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN MACE JR ADDRESS CAMBRIDGE, MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 11/30/79 23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY 23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT - MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 25a. DATE REC'D. BY REGISTRAR DEC 3 1979 25b. REGISTRAR'S SIGNATURE Anthony Anthony | | | | | | | | | | | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

JAN 12 1957

W 7 A

WASHINGTON, D.C.

RECEIVED

RECEIVED

3355

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

324-35-0785

W 11

YES

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

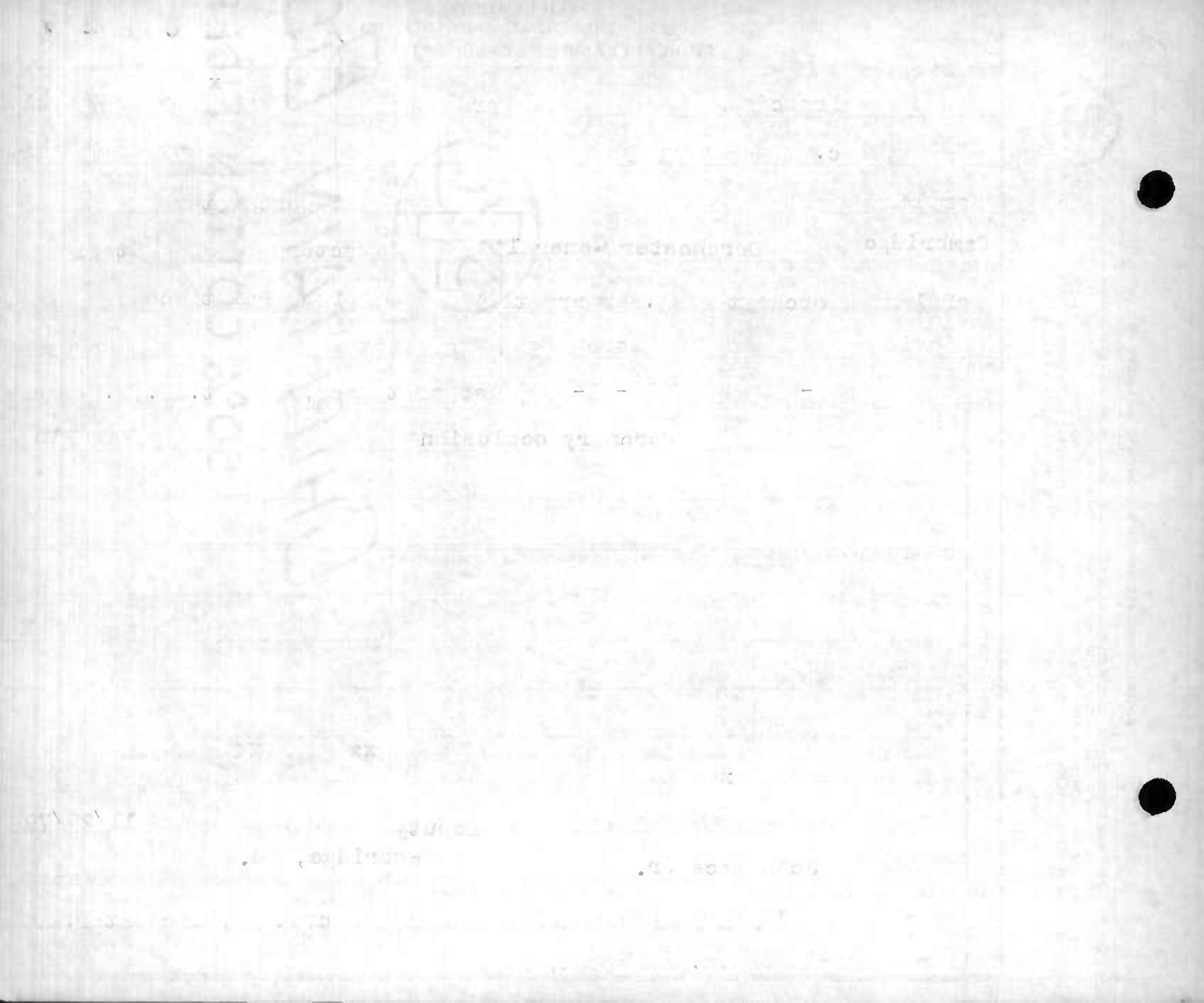
RECEIVED

RECEIVED

RECEIVED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 9 28129 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| FOR
1- STATE REGISTRAR | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | | | | | | REG. NO. | |
| Francis Ward | | | | | | | | | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR | |
| 3. SEX Male 4. RACE Cauc. 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS. | | | | | | | | | | 21. DATE PRONOUNCED DEAD MONTH DAY YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH Cambridge 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory 12b. KIND OF BUSINESS OR INDUSTRY Steel | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland 13b. COUNTY Dorchester 13c. CITY OR TOWN E. NewMarket | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Green Point Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Ward | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Murphy | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) -- 16b. SOCIAL SECURITY NO. 218-01-2649 | | | | | | | | | | 17. INFORMANT ADDRESS Margaret Ward, GreenPt. Rd., E. NewMarket | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
410-
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Min | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D. Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 11/29/79 | |
| EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. ADDRESS Cambridge, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 12/1/79 23c. NAME OF CEMETERY OR CREMATORY Our Lady of Good Counsel | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Secretary, Dorchester, MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Zeller Funeral Home, E. NewMarket, MD | | | | | | | | | | 25a. DATE RECD. BY REGISTRAR 11/29/79 25b. REGISTRAR'S SIGNATURE | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after medical examiner may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Raymond Calvin Webb | | | | | 2a. DATE OF DEATH MONTH 11 DAY 21 YEAR 79 2b. HOUR 5 M PM | | | | |
| 3. SEX m | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH 9 DAY 31 YEAR 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY FARMING | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Wilkes 13c. CITY OR TOWN Willards | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Reginald Ave Box 4 | | |
| 14. FATHER'S NAME FIRST William MIDDLE H. LAST Webb | | | | | 15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE Alice LAST Wilkins | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-28-4253 | | 17. INFORMANT ADDRESS Mrs. Hettie Aydelotte (sister) same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brouchopneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (b) 485- DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Alpeuric Brain Syndrome | | | | | | | | | |
| 19a. DATE OF OPERATION 9-7-79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH 11 DAY 21 YEAR 1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET 17 Franklin St CITY OR TOWN Cambridge Md COUNTY 21613 STATE MD | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-1-79 to 11-21-79 , that (I) (we) last saw the deceased alive on 11-21-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE E. Tannan DEGREE MD | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tannan | | | | | 22e. ADDRESS 17 Franklin St Cambridge Md 21613 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/26/79 | | 23c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery | | 23d. LOCATION CITY OR TOWN Willards COUNTY Wilkes STATE Maryland | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME ADDRESS Salisbury, Md. | | | | | 25a. DATE RECD. BY REG. CLERK NOV 20 1979 | | 25b. REGISTRY SIGNATURE [Signature] | | |

RECEIVED
JAN 11 1968
U.S. AIR FORCE

100-100000

SAFETY - 100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 7 9 2 8 1 3 1 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Marie E. Wilkins White | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 10 79 | | | |
| 3. SEX Female | | | | 2b. HOUR 6:30 PM | | | |
| 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 04 01 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland USA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD. | |
| 10. CITY OR TOWN OF DEATH Cambridge, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Shore Hospital Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Pat Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Virgil Peetham Wilkins | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Middleton | | 16. STREET ADDRESS Baysinger Trained Court | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-38-0526 | | 17. INFORMANT John D. Parsons - Home For The Aged | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) Pneumonia | | DUE TO, OR AS A CONSEQUENCE OF (b) Senile dementia | | 11/6 - 11/10 | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF (c) | | 8/20/79. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile dementia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/9/79, 1979, to 11/10/79, 1979, that (I) (we) last saw the deceased alive on 11/10/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE E. Gonzalez | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/10/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDULFO GONZALEZ | | 22e. ADDRESS E.S.H.C. Cambridge Md. 21613 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE Nov. 13/79 | | 23c. NAME OF CEMETERY OR CREMATORY PARSONS Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wico. Md. | |
| 24. FUNERAL DIRECTOR NAME Holloway Funl Home P.A. | | ADDRESS Salisbury, Md. | | 25a. DATE RECD. BY REGISTRAR NOV 13 1979 | | 25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy | |



Male E. Atkins, White

Female Gussman, 44 01 28

Marshall USA U.S.A.

Donnell, (and)

Grandchild, 1st Eastern Shore Hospital (after) Retired - 1st class

Marshall, 1st class, 1st class, 1st class

Virgil

William Atkins

Sally

Middleton

No

812-38-0222

John & Patricia Atkins, The Road
to the Hill, Salisbury, Md 21081

11-11-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-359-0991.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 7 9 2 8 1 3 2 | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Elinor | | MIDDLE
Ross | | LAST
Wier | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| 3. SEX
F | | 4. RACE
Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR
1 03 00 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | 7b. HOUR
140 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Dorchester MD. | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DGH. Dorchester Gen. Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
xxxx Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY
Retail Cloth-
ing | |
| 13a. STATE
MD | | 13b. COUNTY
DOR | | 13c. CITY OR TOWN
Cambridge | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
114 High St. | |
| 14. FATHER'S NAME
FIRST
William M. Ross
MIDDLE
WILL | | 15. MOTHER'S MAIDEN NAME
FIRST
Mary
MIDDLE
Duvall
LAST
Duvall | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-10-9345 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrocardiac dysfunction</u>
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> 19 <u>79</u> to <u>11/12</u> 19 <u>79</u> , that (I) (we) lost
saw the deceased alive on <u>11/12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Ann Wilke</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
11/12/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ann Wilke MD | | | | 22e. ADDRESS
Cambridge Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
Nov. 15, '79 | | 23c. NAME OF CEMETERY OR CREMATORY
xxxxxx Christ Church | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cambridge, Dorchester, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Curran Funeral Home, 308 High St. | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 14 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Ruby McCreedy</u> | | | |

Current Funeral Home, 305 Main St.
Cambridge, Mass.
Nov. 15, 1935
Christ Church

220-10-3345

William A. Rose

Dorchester

Cambridge

Dorchester

Rose

view

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|-----|--|--|--|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Harrison | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 10-14-79 | | | | | | | | | | 2b. HOUR
A.M. | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
3-26-1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
Oct. 14, 1979 | | 7d. HOUR
11 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Dorchester County | | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DOA Dorchester General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Farm | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Md. | | | | 13b. COUNTY
Dor. | | | | 13c. CITY OR TOWN
Cambridge | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
RFD 1 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Woolford | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Shirley ? | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
? | | | | 17. INFORMANT
St. Clair Funeral Home | | | | ADDRESS | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute ethylism, drowning
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Few mins. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
? P.M. 10/14/79 | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 10/14/79 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Apparently had been drinking and fell | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Ditch | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
R.F.D. Cambridge Dor. Md. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John Mace Jr.</i> | | | | TITLE (SPECIFY)
Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED
11/16/79 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John Mace Jr. M.D. | | | | ADDRESS
Cambridge, Md. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
10/18/79 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Bethel Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cambridge Dor. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>St. Clair</i> | | | | ADDRESS
Cambridge, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 26 1979 | | | | 25b. REGISTRAR'S SIGNATURE
<i>Ray</i> | | | | | | | | | |

MEDICAL CERTIFICATION

